BENEFITS

NAU NORTHERN ARIZONA UNIVERSITY

Human Resources

Unum Short Term Disability

- Unum Short Term Disability insurance provides a benefit of up to 70% of your pre-disability weekly pay.
- There is a 30-day waiting period before the benefit begins, unless you are admitted to the hospital for 24 or more hours or have had outpatient surgery.
- You must not be working in any capacity to qualify for benefits!

How to apply for short term disability benefits

To file your claim, you will need to submit the following completed form(s)

Unum Claim for Disability Benefits Form – *To be completed by all employees*

This form has three sections to complete.

1. **Insured's Statement:** Fill out this section first. Be sure to sign and date.
2. **Attending Physician's Statement:** After you have completed the Insured's Statement, your physician will need to enter your disability details in this section.
3. **Employer Statement:** Once the Insured Statement and Physician Statement are completed, **return the form to Human Resources to complete t section.** We will submit the form to Unum for processing.

Hospital Form – *To be completed by employees with a hospital stay of 24 hours or more or had outpatient surgery*

In order to have the 30-day waiting period waived you will need to have the facility or physician complete the Hospital Form after your admission or procedure.

Return the completed form(s) to Human Resources by email, fax, or mail.

- Email: NAUHRBenefits@nau.edu Fax: (928) 523 -7486
- Mail: PO Box 4113, Flagstaff, AZ 86011

How to report your time away from work

If your claim is approved, you will receive 70% of your pre-disability weekly pay from Unum. You are required to report at least 30% of your pay with sick, vacation or compensatory time (in that order). For example, if you work 80 hours per pay period you would report the following:

- 24 hours of sick time
- 56 Hours of leave without pay

If you have any questions about how to apply for Unum short term disability contact Human Resources at NAUHRBenefits@nau.edu or call (928) 523 - 2223.

Claim for Short Term Disability Benefits
P.O. Box 100158 Columbia, SC 29202 - 3158
Telephone: (800) 858 - 6843 Fax: (800) 447 - 2498

Insured's Statement

1. Insured's full name ____________ Social Security No.____________
   Street and No. ____________ City ____________ State ________ Zip Code ________
   Birthdate____________ O Male O Female Telephone Number____________
2. Date sickness began or injury occurred ____________ Date last worked ____________
3. Date of first treatment by a physician for present disability ____________
4. State nature of sickness or injury ____________
5. If injured, state how and where the injury occurred ____________
   ____________Did injury occur on duty? O Yes O No
6. From and to what dates were you continuously totally disabled and prevented from performing any work?
   From ____________ To ____________
7. Date you were first able to do any work? ____________
8. Has claim been filed or will claim be filed under any Worker's Compensation Act or similar law? ____________

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, in Florida, a felony of the third degree.

I hereby authorize any hospital, physician, or surgeon to furnish the Provident Life and Accident Insurance Company any information desired.

Insured Signature ____________Date____________

Attending Physician's Statement

Patient's Name ____________ Age ____________

1. Nature of sickness or injury (Describe complications if any)____________
   ____________ ICD 9 CODE NO. ____________
2. Did this sickness or injury arise out of patient's employment? O Yes O No
   If "yes", explain____________
3. Is disability due to pregnancy? O Yes O No What is the expected delivery date or actual delivery date? ____________
   Type of delivery O Cesarean O Vaginal Please describe any complications ____________
4. Nature of surgical or obstetrical procedure, if any, (describe fully).____________
   ____________Date performed ____________
5. Give dates of treatment:
   Date if first office visit ____________ Date of last office visit: ____________
6. Hospital: Admission date ________ time ________ Discharge date ________ time ________
7. The patient has been continuously disabled (unable to work) from____________through ____________
8. Remarks: ____________

Date	*Attending Physician's Signature*	*Telephone Number* / *SSN or Employers ID No.*

Street Address	*City or Town*	*State*	*Zip Code*

Employer's Statement

1. Insured's full name ____________ Birthdate____________
   Social Security No.____________ Occupation____________
2. Date Employed ____________ Date insured____________
3. Was Insured's premium paid when disability began or loss occurred? O Yes O No To what date have premiums been paid? ____________
4. Has claim been filed or is it possible that claim will be filed under any Worker's Compensation Act or similar law? O Yes O No
5. Date Insured last worked____________A.M. P.M Policy No. 498035 Claims Division 003
   Date resumed work ____________A.M. P.M Name of Company Northern Arizona University
6. Weekly Earnings ____________ Address P.O. Box 4113, Flagstaff AZ 86011 – 4113
   O Option A O Option B O Option C Department Human Resources (928) 523 – 2223
   Remarks ____________ Signed ____________
   ____________ My Position is ____________ Date ____________

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BENEFITS

Human Resources

Unum Provident Life and Accident Insurance Company
Claim for Disability Benefits
P.O. Box 100158
Columbia, SC 29202-3158

FAX: (800) 447 - 2498

Dear Claims Representative,

This letter is to confirm that the following employee who has submitted a claim for Short Term Disability Benefits was confined in-patient in a hospital for a minimum of 24 hours or had out-patient surgery.

Name: ______________________________________ **SSN:** ______________________________________

To be completed by the patient's Health Care Provider after the procedure or discharge

Select the type of admission and provide the requested information

☐ Hospitalization Date: ___________ Time: ________ a.m. / p.m. Date: ___________ Time: ________ a.m. / p.m.

☐ Outpatient Surgery Date: ___________ Time: ________ a.m. / p.m. Date: ___________ Time: ________ a.m. / p.m.

☐ Birth of a Child Date: ___________ Time: ________ a.m. / p.m. Date: ___________ Time: ________ a.m. / p.m.

Baby's Date and Time of Birth: ____

Type of Delivery: ☐ Normal Delivery ☐ C-Section

____ ____________________________

Signature of Health Care Provider *Date*

Thank you in advance for your prompt attention to this matter. If you have any questions, please contact Human Resources at (928) 523 - 2223 or nauhrbenefits@nau.edu